DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03 — 07 MA

2. STATE: New Jersey

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
August 13, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1932 of the Social Security Act
42 CFR 438

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ -0-
b. FFY 2004 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Table of Contents, List of Attachments, pp1, 3
Pages 9,11, 22, 41, 45(a), 45(b), 46, 50a, 55, 71, 77, 78a, 78b
Attachment 2.2-A, page 10, 10a
Attachment 3.1-F
Attachment 4.30

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same
Same
Same
New
New

10. SUBJECT OF AMENDMENT:
Section 1932 Preprint Revisions to Managed Care

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Not required, per 7.4 of the Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Gwendolyn L. Harris

13. TYPED NAME:
Gwendolyn L. Harris

14. TITLE:
Commissioner

15. DATE SUBMITTED:

16. RETURN TO:
Jean Cary
Division of Medical Assistance and Health Services
P.O. Box 712 #26
Trenton, NJ 08625-0712

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 30 2003

18. DATE APPROVED: MAR 17 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
AUG 13 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Sue Kelly

21. TYPED NAME:
Sue Kelly

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

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LIST OF ATTACHMENTS

No.	Title of Attachments
*1.1-A	Attorney General's Certification
*1.1-B	Waivers under the Intergovernmental Cooperation Act
1.2-A	Organization and Function of State Agency
1.2-B	Organization and Function of Medical Assistance Unit
1.2-C	Professional Medical and Supporting Staff
1.2-D	Description of Staff Making Eligibility Determination
2.1-A	(Reserved)
*2.2-A	Groups Covered and Agencies Responsible for Eligibility Determinations
	* Supplement 1 - Reasonable Classifications of Individuals under the Age of 21, 20, 19 and 18
	* Supplement 2 - Definitions of Blindness and Disability (Territories only)
	* Supplement 3 - Method of Determining Cost Effectiveness of Caring for Certain Disabled Children at Home
*2.6-A	Eligibility Conditions and Requirements (States only)
	* Supplement 1 - Income Eligibility Levels – Categorically Needy, Medically Needy and Qualified Medicare Beneficiaries
	* Supplement 2 - Resource Levels – Categorically Needy, Including Groups with Incomes Up to a Percentage of the Federal Poverty Level, Medically Needy, and other Optional Groups
	* Supplement 3 - Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
	* Supplement 4 - Section 1902(f) Methodologies for Treatment of Income that Differ from those of the SSI Program

*Forms Provided

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No.	Title of Attachment
*3.1-A	Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy
	*Supplement 1- Case Management Services Supplement 2- Alternative Health Care Plans for Families Covered Under Section 1925 of the Act
*3.1-B	Amount, Duration, and Scope of Services Provided Medically Needy Groups
3.1-C	Standards and Methods of Assuring High Quality Care
3.1-D	Methods of Providing Transportation
*3.1-E	Standards for the Coverage of Organ Transplant Procedures
3.1-F	State Plan Preprint for Mandatory Enrollment into Managed Care
4.11-A	Standards for Institutions
4.14-A	Single Utilization Review Methods for Intermediate Care Facilities
4.14-B	Multiple Utilization Review Methods for Intermediate Care Facilities
4.16-A	Cooperative Arrangements with State Health and State Vocational Rehabilitation Agencies and with Title V Grantees
4.17-A	Determining that an Institutionalized Individual Cannot Be Discharged and Returned Home
*4.18-A	Charges Imposed on Categorically Needy
*4.18-B	Medically Needy- Premium
*4.18-C	Charges Imposed on Medically Needy and other Optional Groups
*4.18-D	Premiums Imposed on Low Income Pregnant Women and Infants
*4.18-E	Premiums Imposed on Qualified Disabled and Working Individuals
4.19-A	Methods and Standards for Establishing Payment Rates- Inpatient Hospital Care

*Forms Provided

TN # 03-07
Supersedes TN # 91-32

Effective Date AUG 13 2003
Approval Date MAR 17 2004

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State: New Jersey

Citation 42 CFR 431.12(b) AT-78-90	1.4	State Medical Care Advisory Committee There is an advisory committee to the Medicaid agency director on health and medical care Services established in accordance with and Meeting all the requirements of 42 CFR 431.12.	
42 CFR 438.104		X	The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with the requirements of 42 CFR 438.104(c) to consult with the Me 'ical Care Advisory Committee in the review of marketing materials.

TN # 03-07
Supersedes TN # 74-07

Effective Date AUG 13 2003
Approval Date MAR 17 2004

OFFICIAL

Revision: HCFA-PM- (MB)

State/Territory: New Jersey

Citation			
42 CFR 435.914 1902(a)(34) of the Act	2.1(b)	(1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.
1902(e)(8) and 1905(a) of the Act		(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.
1902(a)(47) and 1920 of the Act	X	(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.

TN # 03-07
Supersedes TN # 93-19

Effective Date AUG 13 2003
Approval Date MAR 17 2004

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938- OFFICIAL

State: New Jersey

Citation 3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT Services (continued)

42 CFR 441.60 /X/ The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.**

42 CFR 440.240 and 440.250 (a)(10) Comparability of Services

1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g), 1925(b)(4), and 1932 of the Act

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

(iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy. /_/

** Described here:

The Agency and/or its Fiscal Agents, will monitor a sample of claims, conduct peer review, make recommendations to physician case managers, review physician profiles, and conduct a survey of fee-for-service Medicaid patients.

TN # 03-07
Supersedes TN # 91-35

Effective Date AUG 13 2003
Approval Date ~~MAR 17 2004~~

New: HCFA-PM-99-3
JUNE 1999

OFFICIAL

State: New Jersey

Citation	
42 CFR 431.51 AT 78-90 46 FR 48524 48 FR 23212 1902(a)(23) P.L. 100-93 (section 8(f)) P.L. 100-203 (Section 4113)	4.10 Free Choice of Providers (a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy person, or organization that is qualified to perform the services, including of the Act an organization that provides these services or arranges for their availability on a prepayment basis. (b) Paragraph (a) does not apply to services furnished to an individual – (1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or (2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or (3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,
Section 1902(a)(23) of the Social Security Act P.L. 105-33	(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, **or**
Section 1932(a)(1) Section 1905(t)	(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c).

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a), or a managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905 (a)(4)(c).

TN # 03-07
Supersedes TN # 99-19

Effective Date AUG 13 2003
Approval Date MAR 17 2004

Revision: HCFA-PM-91-9
October 1991

(MB)

OMB No.:

OFFICIAL

State/Territory: New Jersey

Citation			
1902 (a)(58) 1902(w)	4.13	(e)	For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met: (1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following: (a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. (b) Provide written information to all adult individuals on their policies concerning implementation of such rights; (c) Document in the individual's medical records whether or not the individual has executed an advance directive; (d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive; (e) Ensure compliance with requirements of State Law (whether

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Effective Date AUG 13 2003
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October 1991

(MB)

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State/Territory: New Jersey

statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as Recognized by the courts of the State) concerning advance directives.

_____ Not applicable. No State law or court decision exists regarding advance directives.

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Supersedes TN # 91-38

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Revision: HCFA-PM-91-10 (MB)
DECEMBER 1991

State/Territory: New Jersey

Citation		
42 CFR 431.60 42 CFR 456.2 50 FR 15312 1902(a)(30)(C) and 1902(d) of the Act, P.L. 99-509 (Section 9431)	4.14 (a)	Utilization/Quality Control A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met: X Directly __ By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO — (1) Meets the requirements of §434.6(a): (2) Includes a monitoring and evaluation plan to ensure satisfactory performance; (3) Identifies the services and providers subject to PRO review; (4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and (5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.
1932(c)(2) and 1902(d) of the ACT, P.L. 99-509 (section 9431)		__X__ A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E of each managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation.